Limited Data Set (LDS) for Hospital Outpatient Prospective Payment System (OPPS) Description, Fields, and Definitions

FILE DESCRIPTION

This file contains select claim level data and is derived from 2005 hospital outpatient PPS claims, updated through June 2006, that is, claims for services furnished on or after January 1, 2005 through December 31, 2005 that were received, processed, paid, and passed to the National Claims History file by June 30, 2006. This file includes more than 58 million claims, for services paid under the OPPS, including observation, multiple and single claims. This is a flat file available on DVD. The record length is 9919, block size is 32760.

Requests for clarification of file description, layout, and definitions only can be accepted at (410) 786-0378.

FILE NAME

XR00.@DBT0992.FIN7.OPPSLDS1.T0061030

FILE LAYOUT

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01  PUF-DATA.
    10  PUF-TYPE                              PIC X(4).
    10  PUF-PROVIDER-NUMBER                   PIC X(6).
    10  FROM-DATE                             PIC S9(5) COMP-3.
    10  SERVICE-LINE-COUNT                    PIC S9(3) COMP-3.
    10  SERVICE-LINE-GROUP.
      15  SERVICE-LINE
            OCCURS 0 TO 300 TIMES
              DEPENDING ON SERVICE-LINE-COUNT.
       25 SERVICE-REVENUE-CODE                PIC X(4).
       25 SERVICE-HCPCS                       PIC X(5).
       25 SERVICE-HCPCS-INITL-MDFR-CD         PIC X(2).
       25 SERVICE-HCPCS-2ND-MDFR-CD           PIC X(2).
       25 SERVICE-REV-CNTR-PACK-IND-CD        PIC X.
       25 SERVICE-MJMC                        PIC X.
       25 SERVICE-DATE-OFFSET                 PIC S9(3) COMP-3.
       25 SERVICE-UNIT-COUNT                  PIC S9(7) COMP-3.
       25 SERVICE-TOTAL-CHARGES               PIC S9(9)V99 COMP-3.
       25 SERVICE-COST                        PIC S9(9)V99 COMP-3.
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CLAIM AND SERVICE LINE FIELD DEFINITIONS:
CLAIM FIELD DEFINITIONS

TYPE: The claim type is either multi-major (MMAJ), multi-minor (MMIN), single major (SMAJ), single minor (SMIN), or observation (OBSV). These claim types are defined as:

> MULTI-MAJOR: Claims with more than one separately payable procedure and/or multiple units of "major" procedures (SI= S, T, V, or X), n=26,619,192. (These are examined carefully for dates of service and content to see if they can be divided into simulated or "pseudo" single claims.)
>
> MULTI-MINOR: Claims with multiple HCPCS, with a status indicator = N, n=49,727.
>
> SINGLE MAJOR: Claims with a single unit of one separately payable procedure (which is called a "major" procedure; SI=S, T, X, or V), all of which will be used in median setting, n=31,455,929.
>
> SINGLE MINOR: Claims with a single HCPCS with SI=N (which is called a "minor" procedure), n= 52,393. These claims may have a single packaged procedure or a drug code. We retain this file as insurance against last minute changes in packaging decisions.
>
> OBSERVATION: Claims with HCPCS G0244 billed, n=142,802.
>
> OTHER: Claims for drugs and devices without a procedure on them, n=46,200.

PROVIDER-NUMBER: The identification number of the institutional provider certified by Medicare to provide services to the beneficiary.

FROM-DATE: The date of service in quarter/year format

SERVICE-LINE-COUNT: The number of revenue codes appearing on the claim.

SERVICE LINE FIELD DEFINITIONS

SERVICE-REVENUE-CODE: The provider-assigned revenue code for each cost center for which a separate charge is billed. A cost center is a division or unit within a hospital (e.g., radiology, emergency room, pathology). Revenue center code "0001" is used to identify the claim "totals" line.

EXCEPTION: Revenue center code 0001 represents the total of all revenue centers included on the claim.

SERVICE-HCPCS: Healthcare Common Procedure Coding System (HCPCS) code for an item or service, is a collection of codes that represent procedures.

SERVICE-HCPCS-INITL-MDFR-CD: Revenue Center HCPCS Initial Modifier Code - A first modifier to the HCPCS procedure code to enable a more specific procedure identification for the claim.

SERVICE-HCPCS-2ND-MDFR-CD: : Revenue Center HCPCS Second Modifier Code - A second modifier to the HCPCS further identifying the specific procedure for the claim.

SERVICE-REV-CNTR-PACK-IND-CD: The code used to identify those services that are packaged/bundled with another service.

SERVICE-MJMC: Each HCPCS code has an indicator for one of the flowing three classifications: J = major; M= minor; B = bypass. This indicator is used to sort the claims into the following groups: single majors, multiple majors, single minors, multiple minors, and non-OPPS claims.

SERVICE-DATE-OFFSET: the number of days from the actual claim date of service. The actual claim date of service is not provided except in quarter/year format, and can be found in the “FROM-DATE” field. This “SERVICE-DATE-OFFSET” field can be used to determine when line items were provided in comparison to other line items on the claim. The value “-999” will be used to indicate that the original line date of service was missing from the data.

SERVICE-UNIT-COUNT: The number of units of the item or service delivered.

SERVICE-TOTAL-CHARGES: The total charges (covered and non-covered) for all accommodations and services (related to the revenue code) for a billing period before reduction for the deductible and coinsurance amounts and before an adjustment for the cost of services provided.

SERVICE-COST: The charges adjusted to cost using the hospital’s specific cost center cost-to-charge ratio